Ravalli County Family Planning **PERSONAL MEDICAL HISTORY**

Please explain any problem(s) under the comment section at the bottom of the page.

A. REVIEW OF SYSTEMS

YES	NO	GENERAL
		1. My health is generally good
		2. Unexplained weight loss/gain more than 10 lbs
		3. Night sweats/hot flashes
		4. Cancer - If yes, where/when?
		5. Birth defects or genetic problems
		6. Are you being treated for any illness/condition now?
		If yes, what _____

7. What medications are you currently taking?
(over the counter, herbal, or prescription) _____

YES	NO	EYES
		8. Eye problems (except glasses or contacts)

YES	NO	EARS/NOSE/MOUTH/THROAT
		9. Hearing problems
		10. Frequent nosebleeds

YES	NO	CARDIOVASCULAR
		11. Mitral Valve Prolapse
		12. Heart murmur
		13. Varicose veins
		14. Blood clots (head/leg/lungs)
		15. Stroke or stroke-like problems
		16. High blood pressure
		17. High cholesterol

YES	NO	RESPIRATORY
		18. Chronic cough or other breathing problem
		19. Asthma
		20. Tuberculosis or exposure to tuberculosis

YES	NO	GASTROINTESTINAL
		21. Stomach or bowel problems
		22. Liver problems (hepatitis or tumor, etc.)
		23. Gallbladder problems

YES	NO	GENITOURINARY
		24. Bladder or kidney problems
		□ Burning urination □ Blood in urine
		25. Uterine fibroids
		26. Ovarian cysts
		27. Breast lump or discharge
		28. Vaginal discharge that itches/burns/has a bad odor
		29. Endometriosis
		30. Vaginal bleeding after sex? ☐ N/A
		31. Previous abnormal Pap smear

Date: _____
Result: _____ Colposcopy☐ Yes ☐ No
Treatment: ☐ Cryotherapy ☐ LEEP ☐ None
Follow-up Paps: ☐ Normal ☐ Abnormal ☐ None
☐ Other:

YES	NO	MUSCULOSKELETAL
		32. Arthritis or osteoporosis

YES	NO	SKIN
		33. Acne or other skin problems-please specify

YES	NO	NEUROLOGICAL
		34. Have you been diagnosed with migraine headaches?

Have you ever experienced any of the following before a headache?
☐ Double vision, blindness ☐ Flashing lights and wavy lines
☐ Numbness or weakness ☐ Speech problems ☐ None of these

		35. Seizures/epilepsy
		36. Numbness in arms/legs (recurring)

YES	NO	PSYCHOLOGICAL
		37. Depression
		38. Psychiatric illness

YES	NO	ENDOCRINE
		39. Thyroid problems
		40. Diabetes/Diabetes during pregnancy

YES	NO	HEMATOLOGICAL/LYMPHATIC
		41. Anemia
		42. Sickle cell disease/trait
		43. Blood clotting disorder

YES	NO	ALLERGY/IMMUNOLOGY
		44. Are you allergic to any drug, medication,latex or other substance, including local anesthesia? What: _____
		45. MMR Immunization Date: _____
		46. Hepatitis B Immunization Date: _____
		47. HPV Immunization Date: _____

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Did your mother take DES when she was pregnant with you to prevent a miscarriage: ☐ Yes ☐No

Has your parent, sibling, or grandparent had any of the following:

YES	NO	DIAGNOSIS	Relative
		Cancer (colon, breast, skin, ovary)	
		Diabetes	
		Genetic problems	
		Heart attack/stroke before age 50	
		High blood pressure	
		High blood cholesterol or fats	
		History of blood clotting disorders	
		Osteoporosis	
		Thyroid problems	

PATIENT COMMENTS / EXPLANATIONS (list by numbers)

Patient Name: _____ DOB: _____ Chart # _____

Ravalli County Family Planning **PERSONAL MEDICAL HISTORY**

D. PREGNANCY HISTORY ☐ **Never Pregnant**

___ Total # of Pregnancies ___ Number of Tubal Pregnancies
___ Number of Live Births ___ Date of Last Delivery
___ Number of Miscarriages
___ Number of Abortions Date of last Abortion _____
Complications: Pregnancy/Abortion

E. CONTRACEPTIVE HISTORY

Current birth control method:
How long used:
Any problems with this method ? ☐ Yes ☐ No
If yes, what:
Are you planning a pregnancy in the NEXT year? ☐ Yes ☐ No

METHODS YOU HAVE USED IN THE PAST:

YES	NO	METHOD	COMMENTS/PROBLEMS
		Abstinence	
		Condoms	
		Depo-Provera (injection)	
		☐ Diaphragm ☐ Cap	
		Hysterectomy	
		Implanon	
		IUD / Mirena	
		Lunelle	
		Natural Family Planning	
		Norplant	
		Oral Contraceptives	
		Patch	
		Ring	
		Sponge	
		Tubal Ligation	
		Vasectomy	
		Withdrawal	

F. SOCIAL HISTORY

YES	NO	HAVE YOU RECENTLY EXPERIENCED:
		Alcohol use - if yes, how many drinks/day
		Eating disorders (bulimia, anorexia
		Forced sex: ☐ Past ☐ Present
		Tobacco use: If yes, how many can/wk or cigs/day
		Physical abuse: ☐ Past ☐ Present
		Sexual abuse: ☐ Past ☐ Present
		Afraid of your: ☐ Partner ☐ Family Member
		Would you like to discuss issues of abuse?

G. MENSTRUAL HISTORY

Age of first period:
Do you have a period every month? ☐ Yes ☐ No How often?
What was the first day of your last menstrual period?
Do you have problems with:
☐ Cramps ☐ Bloating ☐ Emotional Changes ☐ Heavy Bleeding

YES	NO	STI / HIV RISKS
		Age of first intercourse:
		Have you ever used needles to inject drugs?
		If yes, have you shared needles or "works" Examples: injecting drugs, tattooing, piercing
		Have you received blood or blood products since 1978?

History of sexually transmitted infection:
☐ Chlamydia ☐ Gonorrhea ☐ Genital warts ☐ HIV ☐ PID
☐ Hepatitis (A, B, C) ☐ Herpes ☐ Syphilis ☐ Trichomoniasis

Was any partner:
☐ A street drug user ☐ IV ☐ Other
☐ A hemophiliac, or
☐ Infected with HIV / AIDS?

Number of partners in lifetime:
Do you have sex with ☐ Men ☐ Women ☐ Both
Do you use condoms? ☐ Yes ☐ No

Staff Comments:

To the best of my knowledge, the information I have provided is correct and complete.

_____ _____
Client signature Date

_____ _____
Staff signature Date

I have reviewed the above health history and have made notes in the margin to correct and update the information

Date reviewed and updated: _____ Patient initial: _____ Staff Initials: _____

Date reviewed and updated: _____ Patient initial: _____ Staff Initials: _____

Date reviewed and updated: _____ Patient initial: _____ Staff Initials: _____

Patient Name: _____ DOB: _____ Chart # _____